KAMALA D. HARRIS
Attorney General of California
GREGORY J. SALUTE
Supervising Deputy Attorney General
HELENE E. SWANSON
Deputy Attorney General
State Bar No. 130426
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 620-3005
Facsimile: (213) 897-2804
E-mail: Helene.Swanson@doj.ca.gov
Attorneys for Complainant

BEFORE THE
STATE BOARD OF OPTOMETRY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SVETLANA FISHER** **7976 Santa Monica Blvd.** **West Hollywood, CA 90046** **Optometrist License No. 9936** Respondent.	Case No. CC 2007-79 **FIRST AMENDED A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Mona Maggio (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the State Board of Optometry, Department of Consumer Affairs.

2. On or about September 8, 1992, the State Board of Optometry issued Optometrist License Number 9936 to Svetlana Fisher (Respondent). The Optometrist License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2012, unless renewed.

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JURISDICTION

3. This Accusation is brought before the State Board of Optometry (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board/Registrar/Director of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

5. Section 3090 of the Code states:

"Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter or any of the regulations adopted by the board. The board shall enforce and administer this article as to licenseholders, and the board shall have all the powers granted in this chapter for these purposes, including, but not limited to, investigating complaints from the public, other licensees, health care facilities, other licensing agencies, or any other source suggesting that an optometrist may be guilty of violating this chapter or any of the regulations adopted by the board."

6. Section 3110 of the Code states:

"The board may take action against any licensee who is charged with unprofessional conduct, and may deny an application for a license if the applicant has committed unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly assisting in or abetting the violation of, or conspiring to violate any provision of this chapter or any of the rules and regulations adopted by the board pursuant to this chapter.

(b) Gross negligence.

. . .

(d) Incompetence.

. . .

(q) The failure to maintain adequate and accurate records relating to the provision of services to his or her patients. . . ."

7. California Code of Regulations, Title 16, section 1510, provides as follows:

"Inefficiency in the profession is indicated by the failure to use, or the lack of proficiency in the use of the ophthalmoscope, the retinoscope, the ophthalmometer (or keratometer), tonometer, biomicroscope, any one of the modern refracting instruments such as the phoroptor, refractor, etc., or the phorometer-trial frame containing phoria and duction measuring elements or a multicelled trial frame, trial lenses, and prisms, in the conduct of an ocular examination; the failure to make and keep an accurate record of findings, lack of familiarity with, or neglect to use, a tangent screen or perimeter or campimeter; and the failure to make a careful record of the findings when the need of the information these instruments afford is definitely indicated."

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

STATEMENT OF FACTS

9. On or about June 2007, nurse evaluators Elizabeth Schein and Priscilla Tan, who were and are employed by the California Department of Health Care Services (DHCS), Audits and Investigations Division, began their investigation and audit, which included reviewing the patient records of twenty patients examined and treated by Respondent who resided at various Board and Care facilities.[12] Services were rendered by Respondent to those patients and Medi-

[1] In California in the early 1970's the residential care system was established to provide non institutional home based services to dependent care groups such as the elderly, developmentally disabled, mentally disordered and child care centers under the supervision of the Department of Public Social Services. At that time, homes for the elderly were known as Board and Care Homes and the name still persists as a common term to describe a licensed residential care home. In the vernacular of the State, these homes are also known as "Residential Care Facilities for the Elderly".

(continued...)

Cal was billed for 68 services provided to those patients between 2002 through 2006. The DHCS records at issue in this matter concern patient records for service dates from approximately January 2005 through December 2005.

10. Nine patient records that were reviewed were billed as comprehensive eye examinations, on separate dates of service (DOS), as follows:

Record No.	Patient ID[3]	Patient Date of Birth	Date of Service
1	A	4/24/66	1/28/05
5	B	10/28/49	3/21/05
7	D	6/5/81	3/23/05
8	E	12/25/39	7/22/05
9	F	3/21/47	4/12/05
14	J	1/9/57	4/26/05
17	M	11/19/49	4/26/05
23	Q	11/3/62	5/4/05
26	T	12/12/72	9/2/05

11. A second level of review of the medical records, some of which are identified above, was performed by DHCS Medi-Cal Vision Care Program Consultant, Cory Vu, O.D. Based upon his review, Dr. Vu determined that there was poor or inadequate documentation in the majority of records, most of the eye examination forms failed to include Respondent's signature, there was

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Residential care facilities do not provide skilled nursing services (such as giving injections, unless there is a credentialed RN or LVN individual working in the home), but they do provide assistance with all daily living activities, such as bathing and dressing. The patient records at issue in this Accusation note that these patients had eye examinations at the following Board and Care facilities: Gilmar Manor, Rosewood, Walkers Boarding Care, Pleasant View, and Westside Manor.

[2] On or about June 2007, the DHCS requested that Respondent provide additional patient records for 20 patients; 10 records from her office located at 7976 Santa Monica Blvd., West Hollywood, CA, and 10 records from her office located at 906 San Fernando Road, San Fernando, CA.

[3] To protect the patient's privacy, they will each be identified only by an assigned letter identification. The patient records were provided to Respondent's attorney on or about April 19, 2010, in response to a request for discovery from Respondent's attorney. Complainant's attorney did not receive any further requests for patient records, information or any other discovery from Respondent's attorneys.

widespread omission of vision tests on the eye records, and various violations involving Medi-Cal requirements. On or about July 25, 2008, a telephone exit conference was held with Respondent, Respondent's attorney, Dr. Vu, Ms. Schein and Ms. Tan, where the preliminary audit findings that had been sent by fax to her were discussed, and she was given an opportunity to respond to the findings.

12. In a letter dated August 6, 2007, DHCS referred the case to the Board of Optometry for review of the services provided by Respondent to her patients.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence and / or Incompetence)

13. Respondent is subject to disciplinary action under section 3110, subdivisions (b) and (d), in that Respondent provided grossly negligent and / or incompetent care and treatment to her patients, as referenced in Paragraph 10, above, as follows:

a) Respondent failed to complete or had inadequate medical histories in Record Nos. 1, 9, 14, 17, and 23.

b) Respondent failed to do a required annual dilated eye exam for those patients diagnosed with diabetes (see Record Nos. 5 and 8.).

c) Although it was noted in Record No. 5 that the patient had background diabetic retinopathy and reduced best corrected visual acuity (BCVA), Respondent failed to dilate the patient and determine whether the reduced visual acuity was from the diabetic retinopathy which would have necessitated a referral to a retinal specialist for laser treatment.

d) Respondent failed to determine whether there were any signs of diabetic retinopathy in the eyes of the patient in Record No. 8.

e) Respondent failed to perform, or improperly performed, two routine tests for glaucoma, *i.e.*, tonometry and ophthalmoscopy, which are a required standard of care for comprehensive eye examinations. Specifically, Respondent failed to perform tonometry measurements, or intraocular pressure, in Record Nos. 14 and 23 and failed to note the time that the tonometry test was performed in Record Nos. 1,

14, and 23. Respondent further failed to perform ophthalmoscopy and record the cup to disc ratio (C/D ratio) in Record Nos. 1, 5, 7, 8, 9, 14, 17, 23, and 26.

f) Respondent failed to properly record visual acuity (VA) measurements in numerous patients. Specifically, Respondent failed to record the entering VA in Record Nos. 1, 8, 9, 14, 17, and 23, and failed to record the BCVA in Record Nos. 7, 8, 9, 14, 17, and 23.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

14. Respondent is subject to disciplinary action under Section 3110, subdivision (q), in that Respondent failed to maintain adequate and accurate records relating to the provisions of services provided to her patients, as more fully set forth in Paragraphs 9 to 13, above.

THIRD CAUSE FOR DISCIPLINE

(Violation of Regulations)

15. Respondent is subject to disciplinary action under Section 3110, subdivision (a), in that Respondent demonstrated professional inefficiency in violation of California Code of Regulations, Title 16, section 1510, as more fully set forth in Paragraphs 9 to 14, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the State Board of Optometry issue a decision:

1. Revoking or suspending Optometrist License Number 9936, issued to Svetlana Fisher.

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2. Ordering Svetlana Fisher to pay the State Board of Optometry the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: March 1, 2011

MONA MAGGIO
Executive Officer
State Board of Optometry
Department of Consumer Affairs
State of California
Complainant

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